STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 3/25/25 through 3/28/25, on-site visits were conducted at St. Mary's d'Youville Pavilion for the purpose of a Recertification Survey and investigating complaints #ME00047529, #ME00047616, #ME00048781, and #ME00050306. It was determined that St. Mary's d'Youville Pavilion was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 2 of 3 units (3rd floor unit and 4th floor unit) and the laundry rooms for 1 of 1 environmental tour (3/28/25). Findings: On 3/28/25 from 8:20 a.m. to 8:45 a.m., an Environmental Tour was conducted with the Administrator, the Quality Assurance and Performance Improvement Program (QAPI) Manager and the 3rd Floor Unit Manager in which the following findings were observed: Laundry rooms >Clean Linen Area: There were 4 wall mounted fans that were dusty/dirty. There were 2 wall mounted air conditioning units that were dusty/dirty. > Soiled Linen Area: There were 2 wall mounted	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2	F 584		

fans that were dusty/dirty. The ceiling air system, just inside the entrance door, had dusty/dirty filters.

3rd Floor Units (East and West)
> The hallway walls were marred with black marks.
>Resident Room 303 - The privacy curtains were missing hooks, hanging down and in disrepair. The baseboard heater unit was broken apart in the front and was marred with black marks.
> Resident Room 315 - The privacy curtains were missing hooks, hanging down and in disrepair. There was a commode bucket on the bathroom floor. The room base board heating unit was marred with black marks.
> Resident Room 319 - The base board heating unit had chipped/missing paint and was marred with black marks. The walls around the room were marked with black marks.
> Resident Room 320 - The base board heating unit had chipped/missing paint and was marred with black marks.
> Resident Room 321- The base board heating unit had chipped/missing paint and was marred with black marks.
> Resident Room 340 - There were black scuff marks all over the room floor.

4th Floor Units(East and West)
> The East Unit and West Unit hallway walls were marred with black marks.
> Resident Room 435 - There was an unbagged commode bucket on the floor in the bathroom.

On 3/28/25 at 8:45 a.m., in an interview, the Administrator, the Quality Assurance and Performance Improvement Program (QAPI) Manager and the 3rd Floor Unit Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 confirmed the findings.	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 4 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 8 sampled residents reviewed for new admissions (Resident #36). Finding: Resident #36 was admitted in early March of 2025 with a primary diagnosis of fall with right ankle fracture requiring a Lovenox (anticoagulant) injection daily. As of 3/26/25 Resident #36's medical record lacked evidence of a baseline care plan that included the instructions necessary to properly care for him/her, in the area above. On 3/26/25 at 4:39 p.m., the above was discussed with the Director of Nursing.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a physician's order and care plan was followed for 1 of 11 residents reviewed for oxygen therapy (#42).

Finding:

On 3/25/25 at 10:43 a.m., observation of Resident #42 receiving oxygen (O2) via nasal cannula with the oxygen concentrator set at 3 Liters Per Minute (LPM). At this time, the resident stated he/she is on 3 LPM of oxygen. On 3/26/25 at 7:29 a.m., an additional observation of Resident #42 receiving oxygen via a nasal cannula with the oxygen concentrator set at 3 LPM.

Review of the medical record contained a Provider order dated 3/7/25 for "Apply O2 at 4L to keep sats at 93 at rest and 88 with activity. every shift." The resident care plan for "oxygen therapy r/t CHF (congestive heart Failure), Respiratory illness" initiated: 2/28/25. Has interventions of "oxygen settings: O2 via nasal cannula @ 4 L continuous." Further review of the nursing documentation states on 3/10/25, 3/11/25 and 3/15/25 he/she was on 3 LPM of oxygen via nasal cannula.

On 3/26/25 at 11:07 a.m., during an interview, both the Registered Nurse (RN) unit manager and the surveyor observed Resident #42's oxygen set at 3 LPM via nasal cannula. The RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 unit manager stated sometimes the O2 orders will say "titrate" to keep sats at a particular percentage. At this time, both the surveyor and the RN unit manager confirmed the order for O2 therapy was 4 LPM.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a smoking assessment of resident capabilities and deficits to determine resident safety was completed for 1 of 1 resident reviewed for smoking (105). Finding: On 3/26/25 at 8:44 a.m., during an interview with Resident #105, a Registered Nurse (RN) entered the resident's room and removed a lighter from the open nightstand drawer and explained to the resident that having the lighter in his/her room is a hazard and he/she can obtain the lighter prior to going out to smoke. The resident stated he/she is going outside to smoke after breakfast. Review of Resident #105's "Smoking Safety Interaction" dated 3/18/25, states he/she uses tobacco products, has "Poor vision or blindness"	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 and "Unable to extinguish tobacco or marijuana safely". The rest of the form includes the section "Clinical Suggestions" which has; Apply smoking apron, Set up cigarette holder, Staff to extinguish cigarette, Refer to interdisciplinary Team, if Resident deemed unsafe to smoke and Ensure eyeglasses are on", was not completed. On 3/26/25 at 10:43 a.m., during an interview with the RN unit manager, the incomplete Smoking Safety Interaction was reviewed, showing he/she was unable to extinguish tobacco safely. The surveyor asked how the facility knows if the resident is safe to smoke or requires supervision. The RN stated, "We don't go out and observe them. We are a non-smoking facility, but residents have rights" and "They are educated that this is a non-smoking facility." The facilities "Tobacco - and Smoke - Free Policy" approved 2/2022 states, "specific to patients and residents of d'Youville Pavilion: Patients and residents are highly encouraged not to smoke or use tobacco products. They are also educated on the risks of use and strategies to help quit. Due to Patients' Rights in skilled facilities and Long-term care facilities, patients have the right to smoke if they desire to in a safe area. A designated smoking area is available outside at d'Youville Pavilion only to be used by d'Youville Pavilion patients and residents. On 3/26/25 at 4:39 p.m., during an interview with the Director of Nursing, the surveyor discussed the lack of a safety assessment of the resident's capabilities, deficits and whether or not supervision is required.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 8 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care on 3 of 4 days of survey (3/25/25, 3/26/25 and 3/27/25) for 9 of 13 residents reviewed for respiratory care. (#40, #52, #153, #370, #366, #42, #24, #468 and #472) Findings: 1. On 3/25/25 from 9:24 a.m. to 10:23 a.m., and again on 3/26/25 at 7:25 a.m., the following was observed: > Resident #40 had an unlabeled/dated nebulizer pipe stored on the bedside dresser. In a brief interview, the resident stated he/she hasn't had to use the nebulizer in a week. > Resident #52 room had an unlabeled/dated oxygen nasal cannula tubing with the nasal prongs lying on the floor. > Resident #153 room had an unlabeled/dated oxygen nasal cannula tubing wrapped up under the concentrator handle. > Resident #370 room had an unlabeled/dated nebulizer tubing with the open tubing end hanging	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 9	F 695		

over the nebulizer handle.

2. On 3/25/25 at 10:29 a.m., Resident #366 had an oxygen concentrator running, with the open end of the tubing hanging off machine. No one was in the room.

3. On 3/25/25 at 10:43 a.m., observation of Resident #42 receiving oxygen via an unlabeled/dated nasal cannula tubing. On the bedside dresser was a nebulizer machine with an unlabeled/dated mask stored on the back of the machine. Review of Resident #42's medical record lacked evidence of the nebulizer mask, or the nasal cannula tubing changed weekly.

On 3/26/25 at 11:07 a.m., during an interview with the Registered Nurse (RN) unit manager, the above observations were discussed. She stated she had just gone around and removed the concentrators that were not in use and provided bags etc. The Surveyor asked how often O2 tubing and nebulizer masks are changed and how they are stored when not in use. The RN unit manager stated that the facility was in transition with the respiratory therapist leaving and she had been the one changing them. She then stated, you will not find the nebulizer and oxygen tubing changing in the Treatment Administration Record (TAR) and no documentation of changing the tubing weekly is available. The oxygen tubing, nasal cannula, nebulizer tubing and pipe/mask should be changed every week. Nebulizers should be cleansed with water and allowed to dry on a paper towel, then placed in an open plastic bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 10 4. On 3/25/25 at 9:03 a.m. Resident #24 had an unlabeled oxygen tubing/nasal cannula hanging off the bedside table. At this time, the resident stated he/she only needs to use oxygen at night. On 3/26/25 at 8:06 a.m., an additional observation of the unlabeled oxygen tubing/nasal cannula hanging off the bedside table. On 3/26/25 at 11:44 a.m., the above information was discussed with the RN Unit Manager. On 3/27/25 at 12:20 p.m., Resident #24's oxygen nasal cannula tubing was coiled up and stored under the handle of the oxygen concentrator. 5. On 3/25/25 at approx. 8:44 a.m. and on 3/26/25 at 8:07 a.m., observation of Resident #468's and resident #472's unlabeled nebulizer pipe stored in their bedside table drawers. On 3/26/25 at 11:44 a.m., the above information was discussed with the RN Unit Manager. On 3/27/25 at 12:20 p.m., an additional observation of Resident #472's unlabeled nebulizer pipe stored in the bedside drawer. On 3/27/25 at 1:28 p.m., the above information was discussed with the Director of Nursing.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that a resident who requires Hemodialysis receives such services, consistent with the professional standards of practice and failed to ensure the care plan contained the needed information, including emergency interventions necessary to properly care for 2 of 2 residents reviewed for Hemodialysis. (#105 and #32) Findings: 1. On 3/26/25 at 8:32 a.m., the surveyor observed Resident #105 with a bandage to the upper arm. At this time, during an interview, Resident #105 stated he/she has an AVF (Arteriovenous Fistula) and has been going to dialysis for a couple of years. He/she then stated, "Next Friday they are going to do something with my site, the past couple times they couldn't stop me from bleeding and I had to go to the hospital." The surveyor asked if and when the nurses assess and how they monitor his/her AVF site. He/she stated, "They have never touched it" and "no monitoring". Review of the medical record states Resident #105 was admitted to the facility with a diagnosis of End-Stage Renal Disease with an AVF requiring Hemodialysis three times a week. A current physician order states he/she has a "Right Arm AVF revision at [hospital] Day Surgery on 4/4/25". No orders were located to address assessment and monitoring of the dialysis access site. Review of the current care plan lacked interventions for monitoring the AVF site for Bruit and Thrill and emergency interventions if bleeding at the site were observed. Further review of the	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 12	F 698		

medication and treatment administration record lacked evidence of nursing care/assessment and monitoring for the AVF access site.

On 3/26/25 at 4:39 p.m., during an interview with the Director of Nursing (DON) the surveyor discussed the lack of monitoring and emergency interventions in the care plan and treatment record. The DON confirmed the above and was unable to provide a policy and procedure for nursing caring and/or monitoring for a Hemodialysis resident, however, she did provide the surveyor with the "Clinical Nursing Skills, basics to advanced skills" 9th Edition and stated nursing would follow this book for nursing practice.

Review of the "Clinical Nursing Skills" book, section: "Hemodialysis (Renal Replacement Therapy). providing ongoing care of Hemodialysis Client: Procedure ... assess the AV Fistula ... Assessing the Arteriovenous Fistula. Perform hand hygiene. Position clients arm, so fistula is easily accessed. Palpate the area to feel for thrill (vibration). This indicates arterial to venous blood flow in fistula patency. Auscultate with a stethoscope to detect a bruit (swishing noise). This indicates a patent fistula ...Safety alert precautions for fistula or graft ... post safety precautions at head of bed ... regularly feel for vibration thrill over access site. Do not measure blood pressure on the affected extremity. Do not perform venipuncture in the affected extremity. Counsel the client: avoid lying on the affected extremity. Avoid carrying heavy loads with access extremity. Do not wear constrictive clothing on the affected extremity. Immediately report swelling, discoloration, drainage, or coldness, numbness, or weakness of hand."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 13	F 698		

On 3/27/25 at 1:04 p.m., during an interview with 4 surveyors present, the surveyor asked the DON how often nurses should be monitoring AVF for bruit and thrill, she stated, it should be every shift.

2. On 03/25/25 at 9:51 a.m., in an interview with a surveyor, Resident #32 stated he/she has a catheter site in the right upper chest area used for dialysis access. The surveyor asked how often the staff monitor the site. Resident #32 stated staff "look at it on the day of dialysis," and dialysis center staff manage the dressing. The surveyor asked how the catheter is monitored upon return from dialysis, and Resident #32 stated facility staff does not check the catheter site upon return.

Clinical record review noted current physician orders for dialysis on Tuesdays, Thursdays, and Saturdays. No orders were located to address assessment and monitoring of the dialysis access site. A hospice physician's note, dated 2/11/25, noted that Resident #32 has in the "right upper extremity, an AV fistula with intact bruit and thrill."

Resident #32's care plan, last revised 2/17/25, includes the following interventions to address dialysis:
Do not draw blood or take B/P in arm with graft.
Monitor/document/report as needed any s/sx of infection to access site: redness, swelling, warmth or drainage. A review of Resident #32's current medication and treatment administration records did not address monitoring of the dialysis access site (AVF or catheter).

On 3/27/25 at 1:10 .m., in an interview with a surveyor, the charge nurse stated Resident #32's dialysis access site was a hemodialysis catheter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 14 on the right chest which was completely covered by 2 Mepilex dressings that staff send with him/her for every dialysis treatment. Regarding the access site, the charge nurse stated "we do not look at it and do not touch it." The charge nurse stated Resident #32 has an AVF site in the right upper arm which is not used. On 3/27/25 at 1:25 p.m., in an interview with the Nurse Manager, the surveyor discussed that Resident #32's care plan does not indicate that the resident has a catheter for dialysis, does not include regular monitoring of either the AVF or the catheter site (including after hemodialysis treatments), and does not specify emergency procedures to take for complications. On 3/27/25 at 2:00 p.m., the Nurse Manager stated she had called the dialysis center and was advised that only dialysis staff are to maintain the central line catheter and that the AVF was permanently not to be used. There was no further need for monitoring or checking of the fistula site required. In the event of an emergency, staff were to call the dialysis center for instructions. The nurse manager had updated the care plan to include this information.	F 698		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.	F 699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 15	F 699		

This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assess resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 2 of 3 sampled residents reviewed with a current diagnosis of PTSD (Resident #39 and #110).

Findings:

1. A review of Resident #39's Annual Minimum Data Set (MDS) 3.0, dated 2/18/25, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate Resident #39 has an active diagnosis for PTSD.

The surveyor was unable to find information in the clinical record that indicates what Resident #39's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization. In addition, Resident #39's care plan lacked evidence of a trauma informed care plan with identified triggers and interventions to prevent re-traumatization.

On 3/26/25 at 3:12 p.m., the surveyor confirmed the finding above with the Administrator and the Director of Social Services.

2. A review of Resident #110 's clinical record, in the Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate Resident #110 has an active diagnosis for PTSD. The surveyor was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 16 unable to find information in the clinical record that indicates what Resident #110 's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization. On 3/26/25 at 1:15 p.m., in an interview with a surveyor, the Unit Manager confirmed that Resident #110 did not have a care plan (goal, triggers and trauma interventions) for PTSD, other than it being mentioned as one of the problems under focus in the care plan. On 3/26/25 at 2:20 p.m., in an interview, a Licensed Social Worker(LSW) confirmed that Resident #110 did not receive a Psych/PTSD/Trauma Screening/Assessment.	F 699		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 17 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medications were stored properly by having an unlocked, unattended medication cart allowing residents and unauthorized persons access to medications on 1 of 4 survey days. (3/25/25) Finding: On 3/25/25 at 9:15 a.m., a surveyor observed 2 unlocked medication carts located in the hall across from the nurses station on the 3 West Unit. Two staff were observed in an area behind the nurses station and one staff was seated at the nurses station. The surveyor asked the staff seated at the nurses station who the charge nurse was and the staff person pointed to the two staff seated behind her and stated "they both are." At this time, the surveyor opened both medication carts and went through each drawer. No one responded to this. One of the identified nurses got up and walked away. Finally, the surveyor walked over to the remaining nurse and informed her that both medication carts were unlocked. The nurse immediately got up, locked the carts and confirmed the finding.	F 761		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 18 §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on an interview and review of the facility's Quality Assurance and Performance	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 19 Improvement (QAPI), the facility failed to present evidence that the required members attended 2 of 4 quarters provided (April 2024 and July 2024). Finding: On 3/25/25 at 2:43 p.m., a surveyor requested a copy of the attendance sheets for the QAPI quarterly meetings. The Quality Assurance and Performance Improvement Manager provided the surveyor with the meeting attendance sheets. A review of the April 2024 QAPI attendance sheet lacked evidence that the Medical Director attended the meeting. The July 2024 QAPI attendance sheet lacked evidence that the Administrator, Director of Nursing and the Infection Preventionists attended the meeting. On 3/27/25 at 9:19 a.m., during an interview, the above was confirmed with the Quality Assurance and Performance Improvement Manager.	F 868		